STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 08/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 2, 2012 through August 14, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was ninety six (96). The survey sample included forty (40) census sample residents and twenty nine (29) admission sample residents in Stage 1. The Stage 2 sample totaled thirty seven (37) residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	1. R 7 skin tear is healed, physician & RP have been updated 2. Physicians and RP's have been notified for all residents with Change of Condition 3. Licensed nursing staff has been in-serviced by staff development/designee on notification policy. Notification documentation will be reviewed in morning clinical meeting. A random weekly audit of notification documentation will be completed by Unit Manager/designee weekly x 4 weeks, then monthly x 2 months 4. Results will be submitted to QA monthly for review	10/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 9/7/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued im participation.

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that for one (R7) of 37 residents reviewed, the facility failed to immediately consult with the physician and failed to notify the legal representative when R7 sustained a skin tear to the left hand which had the potential for requiring physician intervention. Findings include: R7 was admitted to the facility on 7/2/12 with diagnoses that included dehydration, debility and C2 (cervical spine) fracture. The 7/2/12 nursing admission note stated R7 had a scabbed area on the left wrist. Observation of R7 on 8/2/12 at 11:49 AM revealed that he had a skin tear on his left hand which was covered by Tegaderm (clear wound dressing). R7 stated that he had hurt it on the wheelchair. A second observation of R7's left hand on 8/8/12 at 9:55 AM revealed that he no longer had the Tegaderm dressing and that the skin tear had healed. Review of nurse's notes from 7/2/12 through 8/8/12 failed to mention any incidents where R7	F 157		

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F 157	Continued From page 2 sustained a skin tear to the left hand. Additionally, review of physician's orders for the same time period lacked evidence of any treatment orders. The facility failed to notify R7's physician of the skin tear which had the potential for requiring physician intervention. The facility also failed to notify R7's responsible party (RP) of the skin tear. The RP was not notified until 8/8/12.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. R90 Missing item ($40.00) investigation was completed 9/1/2012 and reported to DLTCRP. R49 Incident report and investigation completed 8/6/2012 and reported to DLTCRP 2. August Incidents & Concerns have been reviewed to assure complete investigation and reporting has occurred when warranted 3. Nursing Management staff has been in-serviced by facility educator/designee on prompt reporting of incidents with investigation results to DLTCRP and thorough	

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F 225	Continued From page 3 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of other documents, it was determined that the facility failed to immediately report, thoroughly investigate and/or report the results of investigations within five (5) working days to the State Agency (Division of Long Term Care Residents Protection-DLTCRP) regarding allegations that had the potential for abuse/neglect of care and misappropriation of property for two (R49 and R90) of 37 Stage 2 sampled residents. Findings include: 1. Review of R90's clinical record revealed a nurse's note dated 6/3/12 that stated, "Resident reported $40.00 missing from the lock box in her room. Resident reported "The nice CNA (Certified Nurse's Aide) who cared for her the previous week, strongly suggested that resident put her money ($40.00) in the lock box at bedside instead of in her wallet which resident states is where she usually keeps her money. This evening, resident went to retrieve the money from the lock box, but it wasn't in there. Resident does not recall anyone going into the box, nor can she recall the name or describe the CNA who placed the money in the box for her."	F 225	investigation of allegations with potential for abuse/neglect and /or misappropriation of property. Incident/concerns will be reviewed in administrative morning meeting until investigation is complete. A random weekly audit of concerns will be completed by NHA/designee x 2 months. Weekly audits of incidents for potential abuse/neglect and reporting will be completed by Unit Manger/designee x 4 weeks, then monthly x 4 4. Results of audits will be reviewed monthly at QA	10/9/12

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F 225	Continued From page 4 Review of the facility's incident report, dated 6/3/12 failed to have documented evidence that this alleged violation of misappropriation of R90's $40.00 was thoroughly investigated. The facility failed to interview and /or obtain written statements from employees potentially involved in the suspected violation. The facility failed to have evidence that an alleged violation involving misappropriation of R90's $40.00 was thoroughly investigated and that the results of the investigation was reported to the State survey and certification agency, the Division of Long Term Care Residents Protection (DLTCRP) within 5 working days of the incident. 2. The clinical record revealed that R49 had a fall on 8/5/12 while being transferred with a Hoyer lift from wheelchair to bed. Review of the Incident Report, dated 8/5/12 revealed that the incident occurred on that date at 2:50 PM. R49 required hospitalization and surgical repair of a right hip fracture. The facility failed to immediately report the incident that had the potential for an allegation of neglect to the DLTCRP and did not do so until 8/6/12 at 8:22 PM (more than 24 hours later). The facility also failed to submit the incident follow-up to the DLTCRP within five (5) working days. The 5 day follow up was not submitted until 8/12/12.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 5 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to promote care in a manner and in an environment that maintained their dignity for five (R20, R51, R76, R80 and R83) of 37 Stage 2 sampled residents. Findings include: 1. Observations on 8/2/12 at 11:05 AM and on 8/8/12 at 4 PM, revealed signage posted over R51's bed that stated, "Nemours re. dental care: Your everyday instructions are as follows: 1. Brush your teeth, 2 times a day especially at gumline. 2. Brush partial dentures and soak in water at night. 3. Limit sweets/candy. 4. Return in 6 mos for a cleaning/exam." The facility failed to ensure that R51's personal care requirements were not posted within view of anyone entering the room. During an interview with E6 (Unit Manager) on 8/10/12 at 11:15 AM she acknowledged that the signage was a dignity issue. 2. Observations on 8/2/12 at 10:35 AM and on 8/8/12 revealed signage posted over R80's bed that stated, "Toilet Resident every Hour." A second sign stated, "Please keep (resident's name) Dental (sic) clean every day Thanks (family)." The facility failed to ensure that R80's personal care requirements were not posted within view of	F 241	1. Signs have been removed from R51, R 80 and R 83's rooms. Meals are served sequentially & in a timely manner to R 11 and R 76. Dignity is maintained before entering room of R20. Staff are knocking and asking permission prior to entering room of resident R20. 2. All posted signs have been removed from resident's rooms. Profile card policy has been reviewed and revised to include adding personal care requirements to residents. Posting of signs and dignity related to entering residents' room have been reviewed with residents during Resident Council meeting and resident's RP's have been notified by NHA via letter. Signage policy will also be included in resident's admission packet.	

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F 241	Continued From page 6 anyone entering the room. During an interview with E6 (Unit Manager) on 8/10/12 at 11:15 AM she acknowledged that the signage was a dignity issue. 3A. During R20's resident interview on 8/2/12 at 10:55 AM, E15 (housekeeping) failed to knock and request the resident's permission before entering the room. Upon seeing the surveyor present, E15 stated, "Oh, sorry" and immediately proceeded to leave the room. 3B. During R20's same resident interview on 8/2/12 at 11:05 AM, E22 (Unit Clerk) knocked on the resident's door and then entered the room without requesting/receiving permission to enter. When E22 saw the surveyor, she said, "Sorry" and proceeded to deliver ID/name bracelets to both resident's in the room despite there being an interview in progress. 4. During the initial tour on 8/2/12 and daily through 8/13/12, observations were made of signage posted on the wall above R83's bed that stated, "Resident is to be toileted before dinner," and another sign that stated, "12-13-10 Please brush (R83's name)'s teeth & (and) dentures every night per her dentist & family. Thank you." During an interview on 8/13/12, E6 confirmed the findings. She immediately removed the signage from the wall and informed the CNA staff that this was a dignity issue. 5. On 8/8/12 during the lunch dining observation on the 3rd floor unit, it was observed that R11 and R76 were seated across from each other at a round table by the nursing station. R11 was	F 241	3. All staff has been in-serviced by staff development/designee on policy regarding posting signs and maintaining resident's dignity/respect when entering resident's room. Nursing and Therapeutic recreation staff has been in-serviced on sequential and timely meal delivery. Random weekly rounds to check for posted signs in resident's rooms will be made by NHA/designee x 3 months. Random audits of resident's profile cards for personal care requirement will be completed by Unit Manager/designee weekly x 4 then monthly x3 Meals will be monitored by nursing/designee 2xper week x 4 weeks then monthly x 3 months 4. Results will be submitted monthly to QA meeting	10/9/12

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F 241	Continued From page 7 served,his lunch first and proceeded to finished his meal while R76 was not served her tray until after R11 had finished his meal. R76 sat there and watched R11 ate his entire meal which took approximately 1/2 an hour.	F 241	With regard to items 2 and 4, these areas had just been spackled the Friday prior to the date of the tour with the Maintenance Supervisor. Those areas have been painted in a timely fashion. With regard to item 1, that door will be replaced, along with all other resident room doors ,during our on-going renovation program. If the "warping" inhibits the proper closure of the door, the door will be retro-fitted to the door frame. With regard to item 3, the area in question will be re-varnished and the door will eventually be re-placed with a new door during the re-novation project.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during environmental tours and interview with the Maintenance Director, it was determined that the facility failed to provide the maintenance services necessary to maintain an orderly interior. Findings include: 1. Observation on 8/7/12 at 2:00 PM of resident room 217 revealed that the front door was warped. 2. Observations on 8/7/12 at 2:04 PM of resident room 216 revealed that the patched ceiling above the washbasin was unpainted. 3. Observations on 8/7/12 at 3:05 PM of resident room 212 revealed that the front door's varnish was peeling. 4. Observations on 8/8/12 at 9:25 AM of the tub room at the East end of hallway A on the second floor revealed that a patched wall was unpainted. An environmental tour with E13 (Maintenance	F 253	1. The Administrator and Maintenance Supervisor will review all other similar areas in the resident living areas to assure that there is no further problem. 2. Maintenance personnel complete a room check each month on every room.; the outcome of these visits is recorded on individual room maintenance reports; we will add to that report "paint/wall repair" and "door condition". 3. Any problems will be brought to the attention of the Administrator by the Maintenance Supervisor. 4. The Maintenance Supervisor will include the outcome of the room visits to the QAA Committee as part of the normal Maintenance QAA Report.	10/9/12

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F 253	Continued From page 8 Director) on 8/8/12 at 10:30 AM confirmed the findings.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that three (R79, R118 and R91) out of 37 Stage 2 sampled residents' care plans were revised to address each resident's problem, changes and needs. Findings include: Cross-refer to F323 example 1 1.R79's care plan was not revised to address the	F 280	1. R79, R118 and R91 care plans have been updated: R79 to include resident behaviors of non compliance and stubbornness. R118 to include change in discharge plan. R91 to include resident's current voiding pattern and degree of assistance. 2. All care plans have been reviewed/up-dated for non-compliant residents, change in discharge planning and change in bladder voiding patterns. 3. Interdisciplinary team has been in-serviced by Staff development/designee on updating care plans in a timely manner for behavioral problems, change in discharge planning and bladder voiding patterns.	

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F 280	Continued From page 9 problem of non-compliance/stubbornness. R79 was non compliant when told not to enter an unlocked storage room. This room contained several motorized wheelchairs, electric wall chargers and various wires cluttered on the floor and was therefore a potential accident hazard to residents. Additionally, interventions were not revised to ensure that this resident received consistent and adequate supervision to prevent an avoidable accident that resulted in injury. 2. R118's care plan included interventions that specifically addressed discharge planning. Interview with E4 (Social Services) on 8/13/12 revealed that the resident will not be discharged as originally planned. However, this resident's care plan was not revised based upon changes in appropriateness of discharge setting and services in a timely manner. Cross refer to F315 3. The facility failed to ensure that the effectiveness of R91's care plan interventions were monitored and re-assessed and the care plan revised based on the resident's voiding pattern and degree of assistance needed.	F 280	Care plans will be updated as needed. Care plans will be randomly audited by MDS coordinator/designee weekly x 4, then monthly X 3 months 4. Results will be submitted monthly to QA for review	10/9/12
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. R118 is no longer *ordered* a fluid restriction R 1 is receiving liquid Omeprazole, as ordered R13 fluid restriction has been discontinued as per Physician orders.	

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with physician's orders and/or the plan of care for three (R1, R13 and R118) of 37 Stage 2 sampled residents. The facility failed to monitor fluid restriction requirements for R13 and R118 and failed to administer medications as ordered for R1 and R13. Findings include: The facility policy entitled, "Encouraging and Restricting Fluids," stated "...Steps: 3. Restricting Fluids: a. Remove the resident's water pitcher and cup from the room. Store in designated area. If the resident refuses to have the water pitcher removed notify the supervisor and in turn the physician. Or, determine the amount to be in the pitcher each shift...f. Record the amount of fluid consumed on the intake side of the intake and output record..." 1. R118 was admitted to the facility on 5/16/12 with diagnoses that included diabetes mellitus, cardiomyopathy, congestive heart failure and Stage 3 chronic kidney disease. Admission orders, dated 5/16/12 included an order for R118 to be on a 1500 ml (milliliters) fluid restriction per 24 hours. On 5/21/12 this order was clarified to state that the 1500 ml fluid restriction allotments were 840 mls for dietary and 660 mls for nursing. A nutrition care plan, dated 5/21/12 noted that R118 was on a 1500 ml fluid restriction.	F 309	Accu-checks are recorded and insulin/sliding scale administered per Physicians order Renvella, loperamide, lisinopril, isosorbide, paxil, prednisone, renagel and nepro are administered and recorded as per physician's orders 2. Fluid restriction policy was reviewed and revised. All residents ordered fluid restrictions were reviewed to comply with updated policy. Physician's orders, care plans and ADL flow sheets were updated to reflect fluid restriction. Fluid restriction orders also communicated to dietary. Pharmacy audited all medication carts to assure liquid medications are available in the facility. MAR'S audited for gaps/omissions, accu-checks/insulin administration and holding of medications with specific parameters	

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F 309	Continued From page 11 The 5/23/12 admission Minimum Data Set (MDS) assessment stated that R118 was cognitively intact and was independent with activities of daily living (ADL). Review of monthly physician order sheets (POS) from 6/12 through 8/12 revealed an order for a 1500 ml fluid restriction per 24 hours. Review of the clinical record revealed that although the facility was documenting on the medication administration records that 220 mls were allotted per each of the three nursing shifts and staff was either initialing and/or checking off, there were no recorded amounts of fluid that had been consumed. Review of meal intake records revealed that fluid amounts consumed by the resident were not monitored separately. Additionally, review of the CNA (Certified Nurse's Aide) ADL Flow Records revealed that CNA's were documenting how many times per shift they were offering fluids to the resident. This flow record failed to note that the resident was on a fluid restriction and failed to document the totals offered to and consumed by the resident. The facility failed to have a system in place to monitor the daily fluid amounts for a resident who was on a 1500 ml fluid restriction per 24 hours. On 7/19/12 a physician's order stated, "Change diet...1500 cc fluid restriction (720 dietary, 780 nursing). On 8/8/12 at 3:50 PM, R118 was observed in his room and had a 16 ounce (480 mls) Styrofoam water cup at the bedside. R118 stated he was aware of his 1500 ml fluid restriction and that his water cup is usually filled once a day.	F 309	3. Nursing, dietary and therapeutic recreation staff was in-serviced by staff development/designee on fluid restriction policy. Licensed nurses have been in-serviced on ordering, administering, refilling and documenting medications. Residents on fluid restriction will be audited by unit manager/designee weekly x 4 then monthly x4. Random weekly audit by Unit Manager/designee of MAR and med availability x 4 then monthly x 4 4. Results of audit will be submitted monthly to QA	10/9/12

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F 309	Continued From page 12 On 8/9/12 at 7:50 AM, R118's breakfast tray meal ticket stated, "1500cc Fluid Restriction/840 cc dietary." The meal ticket failed to have the correct amount allotted to dietary (720 mls) as per the order change from 7/19/12. This breakfast tray contained 4 oz (120 mls) of skim milk and an 8 oz (240 mls) coffee. At 8:20 AM on 8/9/12, R118 was observed in his room after he finished his breakfast. The resident had only consumed the 4 oz of skim milk, had not touched the coffee and had a 16 oz Styrofoam water cup and a half empty 16 oz bottle of Pepsi at the bedside. On 8/10/12 at 11:15 AM findings regarding the lack of monitoring of fluids was reviewed with E6 (Unit Manager). E6 acknowledged the findings. 2. The facility's Medication Administration policy states, "...2. medications are administered in accordance with written orders of attending physicians...10. medications are administered within sixty (60) minutes before or after the scheduled times, except for before or after meal orders...15. If a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time, the space provided on the front of the MAR for that dose is initialed and circled. A reason is documented in the space provided on the MAR...26. If a prescribed medication is not given, the reason shall be recorded on the resident's medical record, and the prescribing practitioner shall be notified of the information under acceptable medical and nursing practices..." On 8/7/12 at 9:39 AM, R1 was observed receiving medications via a feeding tube prepared by E7 (nurse). The medication reconciliation was	F 309		

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F 309	Continued From page 13 completed at 2:30 PM and it was discovered that the medication Omeprazole 5mg/ml suspension give 8ml (40mg) via tube twice a day was ordered but had not been prepared by E7 during the AM medication pass observation. Review of the 8/12 medication administration record (MAR) revealed that the medication was to be given at the 9 AM med pass. Further review revealed that the medication had been initialed by E7 as given. E7 was interviewed on 8/7/12 at 2:40 PM. The surveyor questioned E7 as to why the medication was signed off as having been given when it was not observed being given that morning. E7 stated that she only had the capsule form of the medication and needed the liquid form instead and had to call the pharmacy to order some. When asked why the dose was signed off as having been administered, E7 stated that she should have circled it and proceeded to do so in front of the surveyor. E7 then went to the telephone to call the pharmacy. The facility failed to ensure that R1 received the Omeprazole as ordered by the physician. 3A. R13 was admitted to the facility on 11/17/11 and readmitted on 4/23/12 with diagnoses that included diabetes mellitus, heart failure, hypertension, dementia, chronic diarrhea, and end-stage renal disease (ESRD). The 2/13/12 Quarterly Minimum Data Set (MDS) assessment stated that R13 was moderately impaired for cognition and decision making and required extensive one person assistance with activities of daily living (ADL). Review of monthly physician order sheets (POS) from 5/12 through 8/12 revealed an order for a 1500 ml fluid	F 309		

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F 309	Continued From page 14 restriction per 24 hours. Review of a physician's order, dated 4/25/12 stated, "... 3. Resume Nepro (supplement) 8 oz (ounce) po (by mouth) daily - doc (document) % (percentage) consumed dx (diagnosis) ESRD; 4. Resume 1500 ml (milliliter) Fluid Restriction; Dietary 900 ml Nsg (Nursing) 600 ml: 7-3 (shift) 360 ml, 3-11 (shift) 120 ml, 11-7 (shift) 120 ml." A nutrition care plan, dated 4/5/12 and revised on 4/25/12 noted that R13 was on a 1500 ml fluid restriction. Review of the clinical record revealed that although the facility was documenting on the May 2012 MAR (Medication Administration Record) 600 ml's were allotted for nursing divided as 7-3 (shift) =360 ml; 3-11 (shift) = 120 ml; and 11-7 (shift) =120 ml. The 11-7 shift failed to document recorded amounts of fluid that had been consumed for 10 out 30 days and the other two shifts failed to document any recorded amounts of fluid that had been consumed. Review of the June 2012 POS (Physician's Order Sheet) continued with the same 1500 ml fluid restriction and Nepro order. Review of the June 2012 MAR, from 6/1/12 through 6/18/12 revealed that the facility continued to document the allotted fluid restriction by initialing per shift however, there were no recorded amounts of fluid that had been consumed. R13's physician's order, dated 6/19/12 stated, "Add Nepro 120 cc BID (twice daily) (Record % of intake), ... Cont (Continue) 240 Nepro Q AM, ...1500 cc fluid restriction (720 Dietary, 480 supplement, 360 Nursing (60 cc per Med Pass)."	F 309		

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F 309	Continued From page 15 However, this allotment was greater than the 1500 cc fluid restriction. Staff failed to identify this discrepancy and continued to document the allotted fluid restriction by initialing per shift and again failed to record amounts of fluid that had been consumed. This continued through July 2012 even after R13's physician's order, dated 7/21/12 stated, "RD (Registered Dietician) recommendation ...1500 cc FR (fluid restriction) (720 Dietary, 780 Nursing)". Review of R13's physician order, dated 8/2/12 stated, "RD recommendation/FYI (for your information) + (positive) sig (significant) wt (weight) increase x (times) 1 MO (month),...1500 cc Fluid restriction (720 Dietary, 780 Nursing). D/C Nepro 120 cc BID, Add Nepro 120 cc daily (Record % intake)." Review of the August 2012 MAR revealed continued documentation of the 6/19/12 fluid restriction order by initialing per shift from 8/1/12 through 8/10/12 (11-7 shift) with no recorded amounts of fluid that had been consumed. The 8/2/12 order,"1500 cc Fluid restriction. 720 Dietary and 780 Nursing" was also listed with "FYI" as the only documentation. On 8/7/12 at 8:15 AM, R13 was observed seated across from the nurse's station with an empty meal tray in front of her. R13 stated that she consumed 100% of her meal. R13 stated she had about 1/2 cup of coffee "2 sips" and a juice with her breakfast. During an interview on 8/9/12 at 5:25 PM, E20 (nurse), E14 (RNAC) and E6 (nurse manager) denied completing I & O (Intake & Output) sheets anymore, despite it being part of the facility policy for a resident on fluid restrictions. They all stated,	F 309		

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F 309	Continued From page 16 "We don't do that anymore." During an interview on 8/10/12 at 9:42 AM, E2 (Director Of Nursing/DON) confirmed that I & O sheets are no longer used in the facility. She stated that when residents are on a fluid restriction, they don't get water in their room and the fluid restriction is split up between dietary & nursing. The surveyor showed E2 a copy of facility policy, dated revised 6/2008 and entitled, "Encouraging and Restricting Fluids" procedure which stated to record the amount of fluid consumed on the intake side of the intake and output record. E2 stated that the policy would need to be updated. During an interview on 8/14/12 at 12:35 PM, E23 (CNA/Certified Nurse's Aide) stated that she was unaware that R13 was on a fluid restriction. E23 stated that because she knew R13 was a dialysis patient, she only offers/gives this resident small amounts of water and ice. When asked to show the surveyor how much that would be... E23 indicated that approximately half of a 16oz (480 cc) white foam cup was what she would fill with either water or ice. E23 stated that she documents the number of times she gave water/ice on the ADL flow sheet. When asked how she would know if a resident was on fluid restrictions, E23 stated, "by looking at the CNA book". E23 pulled out R13's sheet, pointed to the word "restriction" and stated that if R13 was on fluid restrictions, "it would be circled... it is not... this gets carried over from month to month." During an interview on 8/14/12 at 12:40 PM, E6 and E24 (dietician) both denied reviewing the resident ADL sheet for fluid intake. They	F 309		

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F 309	Continued From page 17 confirmed that this was not taken into the calculation of nursing allotment of 780 cc of fluid. The fluids/ice offered by the CNA were in addition to the 780 cc of fluid documented on the MAR and the 720 cc allotted for dietary. E6 and E24 confirmed that the resident was exceeding her 1500 cc fluid restriction. When asked who was responsible to review the CNA data, E6 said that she guessed she should but admitted that she had not. E24 also stated that she would have to start reviewing this data when she did her assessments. On 8/14/12 at 12:43 PM, R13 was observed with a carton of milk (120 cc), cup of apple juice (120cc) an empty cup of cranberry juice (120cc) already consumed and in the process of eating a bowl of chicken noodle soup. E25 (nurse) confirmed this observation and that R13's meal ticket only listed the milk and apple juice. He stated that the resident should only receive what is listed on her meal ticket. E25 confirmed the fluids served exceeded the "1500 cc FR" listed on the meal ticket. He denied knowing how this occurred and stated that activity aides serve the soup and pour drinks when residents are first brought to the dining room. During an interview on 8/14/12 at 12:54 PM, R13's lunch observation was discussed with E26 (Food Service Director). He printed out a copy of R13's meal tickets for 8/14/12. He stated that the resident should only have been served what was listed on the meal ticket, that R13 should not have received extra soup or an extra juice. E26 calculated that R13 had at least 600 cc of fluids for lunch plus would have received 240 cc of fluid for breakfast. He confirmed that between	F 309		

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F 309	Continued From page 18 breakfast and lunch, R13 had already consumed 840 cc which was greater than the daily dietary allotment of 720cc and R13 still had not had dinner. R13 was scheduled to have 240 cc of fluid served with dinner. On 8/14/12 at 1:10 PM, E27 (activity assistant), E28 (activity aide) and E29 (CNA/activity aide were interviewed. E27 stated that she observed R13 with an empty soup bowl and empty juice cup. She stated that the resident had requested more soup and another juice from her but that she had informed the resident that she would need to check with nursing because of the resident's fluid restriction. The resident stated, "OK". E27 denied serving liquids to R13. E28 stated that she served one cup of cranberry juice to R13 before her meal was served. E29 stated that the CNA's pass out the soups and not the activity aides. The activity aides all have a dietary list of resident's diet, restrictions, allergies, etc. and gave a copy to the surveyor. They all stated that the resident's tray was not present when juice was poured and when the tray was delivered, substitutions could have been done. However, R13's meal tray was initially delivered to the 2nd floor and they had departed the dining room when the CNA's arrived to serve/offer soup. During an interview on 8/14/12 at 1:20 PM, E30 (CNA) stated that she had observed an empty soup bowl in front of R13 in the main dining room. She stated that the resident told her that she had "only a couple of spoonfuls of soup in her first bowl" and requested more. E30 stated she served R13 a full bowl of soup. She stated that she knew that the resident was on fluid restrictions but did not know the amount of fluid	F 309		

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F 309	Continued From page 19 restriction. E30 stated that usually staff can substitute one fluid for another. E30 admitted that she did not report to nursing that she gave the resident an extra bowl of soup. On 8/14/12, R13 consumed 240 cc fluid for breakfast, 600+ cc for lunch, was scheduled to have 240 cc of fluids for dinner which would equal 1080 cc of dietary fluid plus 780 cc of fluids to be given by nursing which would equal 1860 cc total. (360 cc over the 1500 cc fluid restriction allotted and this did not include any water or ice given by CNAs on all three shifts.) Review of meal intake records revealed that fluid amounts consumed by the resident were not monitored separately. Additionally, review of the CNA ADL Flow Records revealed that CNA's were documenting how many times per shift they were offering fluids/ice to the resident. This flow record failed to note that the resident was on a fluid restriction and failed to document the totals offered to and consumed by the resident. The facility failed to have a system in place to monitor the daily fluid amounts for a resident who was on a 1500 ml fluid restriction per 24 hours. On 8/14/12 at 1:30 PM, findings regarding the lack of monitoring of fluids was reviewed with E6. E6 acknowledged the findings. 3B. R13's June and July 2012 POS's (Physicians Order Sheet) revealed a physician's order that stated, "Novolog (insulin) 100 unit /ml (milliliter) vial - inject subcutaneously (SQ) before meals & bedtime per sliding scale < (less than) 150=0 units; 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units, above 350=5 u (units) & call MD if B/S (blood sugar) is 80 or	F 309		

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F 309	Continued From page 20 less with symptoms, or 60 or less, follow hypoglycemic protocol. Review of a physician's order, dated 7/3/12 at 10:55 AM stated, " 1. Change accuchecks to 4 X (times) day on non-dialysis days & TID (three times a day) on dialysis days..." Review of R13's June 2012 MAR (Medication Administration Record) revealed that on June 2, 2012 @ 6:30 AM R13 had a B/S=196 however, there was no evidence that R13 received the 1 unit coverage of Novolog per the sliding scale as ordered. Additionally, R13's July 2012 MAR lacked evidence that accuchecks were done on four (4) occasions (7/10 @ (at) 11 AM, 7/22 @ 4 PM, 7/21 & 7/22 @ 9 PM) despite the physician's order which was timed QID (four times a day) for 6:30 AM, 11 AM, 4 PM and 9 PM on non-dialysis days, Tues., Thurs., Sat., & Sun. 3C. R13's physician's order, dated 7/3/12 at 10:55 AM stated, "...2. Renvella (used to control phosphorus levels in people with chronic kidney disease who are on dialysis) 1600 mg to TID on non-dialysis days & BID (twice a day) on dialysis days..." Review of R13's July 2012 MAR lacked evidence that R13 received her 4 PM dose of Renvela on 7/21/12 as ordered. 3D. R13's July POS had a physician's order which stated, "Loperamide (anti diarrheal) 2 mg (milligrams) capsule 1 (one) capsule by mouth three times daily..."	F 309		

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F 309	Continued From page 21 Review of R13's July 2012 MAR lacked evidence that R13 received her 9 PM dose of Loperamide on 7/21/12 and 7/22/12 as ordered. 3E. R13's June and July POS's had a physician's order which stated, "Lisinopril (antihypertensive) 2.5 mg tablet 1 tablet by mouth at bedtime. * Hold for SBP (systolic blood pressure/top number of a blood pressure) < (less than) 110". Review of R13's June and July 2012 MAR lacked evidence that R13 received her 8 PM dose of Lisinopril on 6/22/12 and 7/21/12 nor were vital signs done as ordered. 3F. R13's May and July POS's had a physician's order which stated, "Isosorbide MN (mono nitrate) ER (Extended release) 30mg tablet 1 tablet by mouth once daily. DX (diagnosis): HTN (hypertension)." Review of R13's May and July 2012 MAR lacked evidence that R13 received her 8 AM dose of Isorbide on 5/16/12, 5/17/12, and 7/22/12 as ordered. 3G. R13's June and July 2012 POS's had a physician's order which stated, "Paroxetine HCL (Hydrochloride) (antidepressant) 10mg tablet 1 tablet by mouth once daily." Review of R13's June and July 2012 MAR's lacked evidence that R13 received her 8 AM dose of Paroxetine on 6/9/12, 6/28/12, and 7/22/12 as ordered. 3H. R13's July POS had a physician's order	F 309		

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F 309	Continued From page 22 which stated, "Prednisone (steroid) 5mg tablet 1 tablet by mouth once daily." Review of R13's July 2012 MAR lacked evidence that R13 received her 8 AM dose of Prednisone on 7/22/12 as ordered. 3I. R13's June POS had a physician's order which stated, "Renagel (used to reduce serum phosphate levels in the blood) 800 mg tablet 2 tablets (1600 mg) by mouth three times daily with meals. DX: ESRD (End Stage Renal Disease)." Review of R13's June 2012 MAR lacked evidence that R13 received her 5:30 PM dose of Renagel on 6/23/12 and 6/30/12 as ordered. 3J. R13's physician's order, dated 6/19/12 stated, "add Nepro (supplement) 120 cc BID (twice daily) (Record % (percentage) intake)..." Review of R13's June 2012 MAR lacked evidence that R13 received her 5:30 PM and 8 PM doses of Nepro on 6/30/12 as ordered.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	1. R91 was reassessed for bladder incontinence and is currently on a scheduled toileting before meals and HS 2. The Continence Management Program was revised. All residents will have new assessments completed as per new program.	

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F 315	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R91) out of 37 Stage 2 sampled residents, who was incontinent of bladder received appropriate treatment and services to improve or maintain R91's bladder function as was possible. The facility failed to obtain a voiding record for 2 days across all shifts to ascertain R91's voiding pattern as per facility policy and failed to establish a toileting schedule based on the result. R91's admission bladder function assessment was coded 2 (frequently incontinent with 7 or more episodes of urinary incontinence, but at least one episode of continent voiding) compared to his 90 day post admission assessment of coded 3, that is, "Always incontinent" meaning no episodes of continent voiding. R1's bladder function declined from frequently incontinent (coded 2) to always incontinent (coded 3) as per facility assessment. Findings include: The facility's policy and procedure entitled "Bowel and Bladder Rehabilitation Program" was reviewed. R91 had diagnoses that included ESRD (End Stage Renal Disease),dementia mild severity, presumed Alzheimer's type, Possible seizures, hyponatremia, hypertension (HTN), diabetes mellitus (DM), stroke (CVA) and anemia. The clinical record revealed that R91 received hemodialysis services three (3) times a week. According to R91's Minimum Data Set (MDS)	F 315	3. Nursing staff have been in-serviced on the continence management program. Residents will continue to be assessed on admission/readmission, quarterly and with significant change. Random weekly audit will be completed Unit Manager/designee x 4 weeks then monthly x 4. 4. Results will be submitted monthly to QA/QI for review	10/9/12

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F 315	Continued From page 24 comprehensive assessment dated 4/19/12, R91's bladder function was coded as 2 (frequently incontinent). R91 was discharged to the hospital on 4/28/12 and was re-admitted to the facility on 5/8/12. According to R91's 14 day MDS assessment dated 5/15/12, R91's bladder function was coded as 2 (frequently incontinent). On 5/25/12 R91 was found unresponsive and was sent out to the hospital for a change in mental status. R91 returned to the facility on 5/28/12 with a diagnosis of Urinary Tract Infection (UTI). Hospital laboratory urine and culture sensitivity result dated 5/25/12 indicated the presence of "Escherichia Coli bacteria >100,000 CFU/ml". Review of R91's quarterly and most recent Minimum Data Set (MDS) assessment dated 6/1/12 revealed that R91's urinary bladder function was coded as 3 (always incontinent). R91's cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required". R91 needed limited assistance for transferring,bed mobility and dressing; extensive assistance of one nursing staff assist for toileting, hygiene and bathing. R91 did not ambulate and used a wheelchair for mobility device. According to R91's Bladder assessment dated 6/1/12, R91's score was 12 which indicated that this resident needed to be on scheduled toileting. The facility initiated a care plan, dated 3/3/12 (revised 6/6/12) entitled, "resident is incontinent of bowel and bladder and cannot always feel urge to defecate or urinate. Needs physical assistance to toilet. Resident does not always demonstrate	F 315		

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F 315	Continued From page 25 motivation to participate in bowel and bladder retraining." The care plan's goal was, "Resident's incontinence will be managed by staff ensuring that resident remains clean, dry and odor free and skin remains intact". The interventions were: Scheduled toileting Toilet the resident before bedtime Toilet the resident during sleep hours as needed based on the resident's toileting pattern Toilet the resident upon awaking in the morning Toilet the resident before meals Keep resident dry by consistent toileting on a fixed schedule Make no attempt to encourage the resident to delay toileting Record results on the "Toileting Progress Record" Wears adult depends Added on 6/6/12 was "-toilets to BR (bathroom)". According to the facility's "Bowel and Bladder Rehabilitation Program", an Incontinence Management Flow Sheet is used in assessment, documentation and planning steps. Review of R91's clinical record failed to have evidence/documentation that the facility followed facility's procedure on incontinence management. There was lack of documentation that the facility performed the "2 day across all shifts bladder voiding pattern" to ascertain resident's usual voiding times. The scheduled toileting program was based on as " much as possible on the resident's pattern before voluntary control is lost and designed to re-establish or begin a pattern". CNA's bladder function documentation in the ADLs flow sheet did not reflect that there was an individualized toileting program schedule designed for R91 as per the care plan.	F 315		

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F 315	Continued From page 26 Interview with E16 (Unit Manager 3rd floor) and E17 (CNA) on 8/8/12 @ 2:45 PM confirmed that there was no documentation that a voiding pattern was attempted. They will therefore "will schedule today to begin". On 8/10/12 at approximately 1:00 PM there was a urine odor in R91's room. E 18 (LPN) found the odor coming from R91's dirty clothes hamper. The facility failed to ensure that R91, who was incontinent of bladder received appropriate care and services to prevent urinary tract infections and to improve/maintain as much normal bladder function as possible. This finding was discussed with E2 (DON) and E14 (RNAC) on 8/13/2012.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of hospital records and other facility documents, it was determined that the facility failed to ensure that two (R49 and R79) out of 37 Stage 2 sampled residents' environment	F 323	1. R79 motorized wheel chair is stored in locked room. Care plan has been updated for non-compliance and accident prevention. R49 is properly transferred via Hoyer lift as per policy, including guiding resident's legs Handrails are accessible on 1 side of hallway on the nursing units. Hoyer lifts were examined and daily maintenance checks are being completed by maintenance.	

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F 323	Continued From page 27 remained as free from accident hazards as is possible. The facility failed to ensure the environment was free of accident hazards to prevent an avoidable accident that resulted in an injury to R79. The facility was aware that the closet that stored the motorized wheelchairs, battery chargers and coated electric wires cluttered on the floor was kept closed but unlocked and could be accessed by anyone. The facility was also aware that R79 put his motorized wheelchair away in this storage room by himself before bedtime and continued to allow him to do so. R79 was found on his buttocks on the floor, reportedly tripped on a wire , hit his head on the wall as he was putting away his motorized wheelchair. R79 sustained bleeding skin tears on his left hand, a hematoma on the base of his neck and complained of pain. R79 was sent to the emergency room for evaluation and was subsequently admitted to the hospital with a cervical neck (C1-upper cervical spine) and T3 (thoracic spine) fracture. For R49 the facility failed to ensure that staff properly used transfer equipment and followed procedures thereby creating an accident hazard for R49 during a Hoyer lift transfer. The Hoyer lift tipped over, R49 fell and sustained a right hip fracture requiring surgical repair. Additionally, based on repeated observations and interview, it was determined that the facility failed to provide handrail access in the area joining the West end of hallways A and B on the second floor. Findings include: Cross refer F280, example #1 1. R79 had diagnoses that included diabetes mellitus (DM), stroke (CVA), chronic obstructive pulmonary disease, abnormality of gait, muscle	F 323	2. Interdisciplinary staff meeting reviewed residents with potential non-complaint/stubborn behavior. Care plans, ADL flow sheets & profile cards updated to identify behaviors and risk for falls. Residents will continue to be assessed on admission/re-admission, quarterly and significant change. CNA will participate in care planning to determine resident's behavioral problems. CNA staff observed by staff development/designee during Hoyer lifts transfers. All equipment will be stored on one side of hallway to provide handrail accessibility. 3. All staff in-serviced by staff development/designee on reporting resident's behavior problems/changes that could pose potential safety risks and storing equipment on one side of hallway for handrail accessibility. Residents with behavioral problem will be reviewed in	

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F 323	Continued From page 28 weakness, and Dementia- Alzheimer's. According to R79's Admission Minimum Data Set (MDS) Assessment dated 4/23/12 , his cognitive skills for daily decision-making were "moderately impaired:decisions poor; cues/supervision required". R79 was independent in all of his Activities of Daily Living (ADLS) but had physical performance limitations in balance, gait, strength and muscle endurance. R79 had impaired balance during transfers, and gait problems, such as unsteady gait, even with a mobility aid or personal assistance. R79 used a cane and/or motorized wheelchair as a mobility device. R79 received an antianxiety psychotropic drug Clonazepam 0.5 mg tablet 1 tablet twice a day. R79 was assessed as a high risk for falls and had a history of unwitnessed/self reported falls. The facility initiated a care plan for R79, dated 4/26/12 entitled, "Dementia: Resident demonstrates short and long term care memory; demonstrates impaired decision-making ability". The care plan intervention included: "Observe and document behavior carefully; Keep MD informed and Ensure resident safety". Another care plan was initiated on 4/26/12 entitled "Resident is at High Risk for falls secondary to self reported fall" diagnosis CVA/DM.The goal was "Resident will be maintained in a safe environment (as evidenced by) no falls or injury related to falls through nursing intervention and modification of environment x 90 days". The approaches included "increased supervision after room change and Follow Protocol for Prevention of Falls."	F 323	morning meeting. CNA staff in-services by staff development/designee on safe/proper Hoyer lift transfers with return demonstrations Random Hoyer lift transfer observation by staff development/designee will be completed weekly x 2, then monthly X4. Random care plan audits of residents with behavioral problem/safety risk will be completed weekly x 4 than monthly x 4. Random rounds by NHA/designee check if hand rails access is available weekly x 4 then monthly x 4 4. Results will be submitted monthly to QA for review.	10/9/12

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F 323	Continued From page 29 According to R79's 3-11 PM shift nurse's note dated 7/20/12, "Resident was in the room that housed the motorized wheel chairs shouting for help. CNA went to the room to find him on the floor with blood oozing from (L) hand where he had sustained a skin tear. Resident stated "I (sic) putting away my w.c (wheelchair) and when I got up my feet got tangled in the wire (lost his balance per incident report) and I fell back and hit the wall. Resident complained of pain in his neck area,..rated pain as "6" (rated "8"/incident report) unable to lift head upward due to pain...Hematoma at nape of neck Call made to on call physician...order obtained to send to Hospital for evaluation. Resident was found in wheelchair room at 2050 (8:50 PM). Was transported via 911 (hospital ER) at approximately 2115 (9:15 PM)". According to the incident report dated 7/20/12, a neck collar was applied by Paramedic before he was transported to the hospital. According to the hospital MRI (Magnetic Resonance Imaging) findings, R79 sustained fractures of C1 (cervical vertebral body 1), acute fracture of the T3 (thoracic vertebral body) with slight compression, epidural hematoma in the ventral aspect of the spinal canal at the level of C1 and thin hematoma of the posterior aspect of the spinal canal through much of the cervical region. According to the hospital physician's clinical summary and decision making, R79 had "C1 burst fracture, C1-C2 instability and Epidural hematoma. Surgical stabilization would likely be necessary, and would likely involve an occiput to C2 fusion which would likely result in 50%	F 323		

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reduction in the patient's range of motion including flexion, extension and lateral rotation...the patient's family may elect to treat it simply in a collar. However, the injury is unlikely to heal fully.
Nevertheless, surgery may become necessary. The patient is currently on Coumadin (blood thinner). Coumadin will need to be normalized and reversed".

R79 was discharged back to the facility with a Miami-J collar that was to remain on at all times for 8-10 weeks.

In an interview with E19 (CNA) on 8/10/12 at 3:45 PM, she stated that the resident was non-compliant and abusive. He would do what he wanted to do. He always put his motorized wheelchair in the storage room at night without supervision and would not listen to the staff that he was not allowed to go to the wheelchair storage room. (The facility failed to Care Plan for this non-compliance.)

It was observed on 8/10/12 that the motorized wheelchair storage room contained approximately 4 motorized wheelchairs, electric battery chargers on the wall and black coated wires on the floor. A sign was posted on the door that stated "Staff Only" and "Please keep the door closed at all times". According to E19 (CNA), during the 8/10/12 interview, the sign had been posted on the door before the accident occurred and the door had no lock on it prior to R79's fall. A lock was installed after the accident.

Interview with E20 (LPN) on 8/10/12 at 4:00 PM confirmed that R79 had always been

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F 323	Continued From page 31 non-compliant about not entering the storage room by himself. E20 stated, "If I work that side of the unit (passing medication), I watched him. Last night, he tried to do it again but the door was locked. He waited for a while, then he did not attempt anymore to open it and went back to his room". The facility failed to ensure the resident's environment was free from accident hazards when the storage door was unlocked which housed numerous electrical wires and motorized wheelchairs accessible to R79. This finding was discussed with E1(Administrator) and E2 (DON) on 8/14/12. 2. R49 was admitted to the facility on 12/19/11. Diagnoses included congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and muscular dystrophy. According to both the 12/28/11 admission Minimum Data Set (MDS) assessment and the 6/28/12 quarterly MDS assessment, R49 was cognitively intact and was totally dependent on 2 staff for bed mobility and transfers. These same MDS assessments stated that R49 did not ambulate in the room or in the corridor. The facility developed a care plan for ADLs (Activities of Daily Living) on 12/29/11, which was last reviewed on 7/5/12. This care plan stated that R49 required maximum assistance of 2 staff for transfers with a Hoyer lift.	F 323		

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F 323	Continued From page 32 The facility policy entitled, "Mechanical Lift" stated, "...Guidelines: The portable lift is to be used by two nursing assistants to perform the procedure...Steps:..10. To put the resident back to bed, you should:..f. Assist the resident in guiding his or her legs..." An Incident Report, completed on 8/5/12 at 2:50 PM by E12 (nurse) stated "Heard a loud noise from residents room upon entering the room I saw resident lying on right side of bed on the floor on his back with the lift wedged between the bed and bedside table. Resident was still hooked up to hoyer lift denied hitting his head (complained of) right hip pain." Review of the Fall Investigation Form, dated 8/5/12 revealed that R49 was being transferred from a wheelchair to bed via a Hoyer lift by E10 (Certified Nurse's Aide-CNA) and E11 (CNA). The clinical record revealed that R49 was sent out to the hospital on 8/5/12 for evaluation of the right hip pain and was subsequently admitted for a right hip fracture that required surgical repair. R49 returned to the facility, post hospitalization, on 8/8/12. A Reportable Statement completed by E11, dated 8/5/12 stated, "(R49) asked me to put him to bed at 2:30 PM and I asked (E10) to help me get him into the bed. In the process of putting him to bed the machine till (sic) over and he fall (sic) at the right side off (sic) the bed." A Reportable Statement completed by E10, dated 8/5/12 stated, "(E11) ask me to help her put (R49) in the bed. As she trun (sic) to put him in the bed the lift tilt over...I was in the room with (E11) at the time this happing (sic)." A second Reportable	F 323		

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F 323	Continued From page 33 Statement completed by E10, dated 8/6/12 stated, "I (E10) was ask (sic) by (E11) to spot her with (R49) I did so First we wt (weighed) him then (E11) start to turn the lift toward the bed the next thing i new (sic) the lift was on it side and (R49) was on the floor." On 8/13/12 at approximately 2:00 PM, E10 was interviewed in R49's room. E10 was asked to describe and demonstrate what had occurred on 8/5/12 when R49 had the fall while being transferred with the Hoyer lift. E10 stated that she was asked to "spot" the Hoyer transfer from wheelchair to bed. She stated that the resident's wheelchair was positioned at the foot of the bed, facing the doorway and that R49 was assisting E11 in hooking up the sling straps to the Hoyer lift. E10 stated that E11 said she had to weigh the resident so she (E10) stepped over to the resident's right side to zero out the scale on the Hoyer, and then they lifted and weighed R49. E10 stated she then had to step back, off to E11's left, as she had to back the Hoyer out in order to then get it into position under the bed. When asked, E10 stated that the legs of the Hoyer were opened appropriately because of the resident's oversized wheelchair and that the bed was in mid position and not in the low position. She stated that the wheels on the Hoyer were not locked (according to the facility's "Safe Transfer: Mechanical Lifts-Hoyer...The wheels of the lift are never to be locked unless lift is being stored. Locking of the wheels during transfer may cause the lift to tilt."). She said that E11 had to back up and turn the lift and then it tilted and the resident fell to the floor. E10 stated that the lift fell onto the edge of the over bed table which was off to the side of the bed headboard. E10 stated that she	F 323		

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F 323	Continued From page 34 did not see anything done incorrectly. According to her statement, E10 was standing behind and to the right of E11 when she was maneuvering the Hoyer back and towards the bed. E10 did not guide the resident's legs or have a hold on the sling. On 8/13/12 at 2:20 PM, R49 was attempted to be questioned about the fall. He became very angry and said that he was "sick and tired of everyone asking him about this repeatedly." He did state that the hoyer tipped and that he has felt it tipping in the past during various transfers, so he doesn't understand why everyone is saying that they shouldn't tip over. R49 did state that the machine was working correctly and that the aides "did nothing incorrectly." On 8/13/12 at 3:10 PM, E11 was interviewed by two (2) surveyors. A Hoyer lift (not the lift involved) was taken into R49's room and E11 demonstrated how she transferred R49 on 8/5/12. E11 demonstrated that she backed up the hoyer then proceeded to direct the Hoyer legs under the bed. Prior to directing the legs under the bed she slightly closed the legs of the Hoyer (this particular Hoyer only had 2 locking positions for the legs; wide open or closed/parallel). She stated that when she started pushing the legs under the bed, the lift tilted and the resident landed on the floor near the head of the bed. On 8/14/12 at 10:15 AM, E1 (Administrator) was interviewed. E1 stated there was no identified problem with the Hoyer, and that the CNAs did not say there was an operational problem with the hoyer. Despite this whenever there is a problem with equipment, it is removed from the floor and	F 323		

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F 323	Continued From page 35 checked by Maintenance, who did not find any problems with the lift. Additionally, the lift supplier was called in to check the lift. An adjustment was done to a spring inside the mechanism to tighten the locking of the base legs when in closed or open position, but that this adjustment was routine and not the cause of the fall. Although R49's Hoyer transfer was completed with two (2) staff in the room, there is no evidence that staff were holding onto the sling/resident while the lift legs were being positioned under the bed. The staff failed to follow the facility policy which states "Assist the resident in guiding his or her legs." In an interview with E9 (CNA) on 8/14/12 at 11:00 AM, E9 stated that during a Hoyer transfer two CNAs are in the room. One CNA operates the Hoyer controls and the other guides the resident with the strap on the back of the sling. She stated that at times due to the size of the room and equipment it is hard to maneuver in the room, as they are small and sometimes crowded. In an interview with E8 on 8/14/12 at 11:20 AM, E8 stated 2 CNAs are present during a Hoyer transfer, one controls the Hoyer, the other guides the resident with the strap on sling. Stated she always makes sure that she has space to work and clears clutter out of the way. 3. Repeated observations and interviews revealed that the facility failed to provide handrail access in the area joining the West end of hallways A and B on the second floor. Observations are as follows: On the second floor on 8/2/12 at 8:10 AM	F 323		

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F 323	Continued From page 36 revealed that the handrails on one side of the back hall were obstructed by an empty portable trash cart, Diapulse machine, hoyer lift and one (1) Geri-chair outside of room 218. On the back hall, the handrails on one side were obstructed by a motorized chair and one (1) Geri-chair and on the opposite side there were two (2) wheelchairs. Hall B had equipment stored on both sides of the hall. Observations were confirmed by E14 (RNAC). E14 instructed staff to move equipment to one side of the hall. On the second floor on 8/2/12 at 8:15 AM revealed that at the corner of Hall B and the back hall by room 226, there was a floor "caution" cone in the hallway which opened to a very small area to walk through on the back hall between rooms 226 - 201. The handrails on both sides of the back hallway between rooms 226 and the locked storage room were obstructed by two (2) wheelchairs and a hoyer lift and from the locked storage room to room 201, there was one (1) foam chair and a flat bed maintenance cart. On the opposite side of the hall, there were three (3) wheelchairs and a Geri-chair. At 8:25 AM, observations were confirmed by E6 (nurse manager) who stated, "Well, it should be on one side of the hallway and not all jammed up like this... the cart was probably left by maintenance and should be in the basement as well." E6 proceeded to move equipment to one side of the hall. On the second floor on 8/8/12 at 11:15 AM revealed that the handrails on one side were obstructed by two (2) Geri-chairs and a Geri-chair and wheelchair on the opposite side. Observations were confirmed by E10 (CNA).	F 323		

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F 323	Continued From page 37 On the second floor on 8/9/12 at 12:00 PM revealed that the handrails on one side of the hallway were obstructed by two (2) wheelchairs and two (2) Geri-chairs, an oxygen cylinder, linen cart and a walker on the opposite side.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 329	1. R49 Trazadone effectiveness/side effects are monitored and recorded R7 Resident is no longer a resident at the facility R47 Results of D3 level are in clinical record. BMP/HgbA1c was drawn 8/14/12 and in clinical record. **R14** Blood pressure and heart rate are obtained and recorded for Metoprolol. Medication is administrated or held as per ordered parameters and documented accordingly to physician's orders. **R13** Blood pressure is obtained and recorded for Lisinopril, as ordered. Blood pressure & heart rate is obtained and recorded for Coreg, as ordered. Medications are administered or held as per ordered parameters and documented accordingly to physician's order. **R75** Blood pressure and	

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F 329	Continued From page 38 determined that the facility failed to ensure that six (R7, R13, R14, R47, R49 and R75) out of 37 Stage 2 sampled resident's drug regimen was free from unnecessary drugs. Findings include: 1. R49 had a physician's order, dated 12/25/11 for Trazadone 50 mg 1 tablet by mouth at bedtime for insomnia. A care plan initiated on 12/29/12 for the problem of potential for psychotropic drug related side effects identified the goal as the resident will be free from side effects and will sleep 6-8 hours per night. Approaches included monitoring for effectiveness and side effects. Review of the clinical record lacked evidence of any monitoring of the effectiveness of the Trazadone for insomnia and lacked monitoring for potential side effects. R49 continued to receive Trazadone for insomnia on a daily basis. 2. R7 had a physician's order, dated 7/2/12 for Ativan 0.5 mg by mouth every 6 hours as needed (PRN) for agitation. A care plan initiated on 7/13/12 for the potential for side effects from anxiolytic medication included the approaches, "monitor for effectiveness and side effects; for PRN medications, refer to behavioral monitoring sheets on MAR (medication administration record). Document alternatives to decreasing anxiety before giving medication. Document outcome." The 7/12 MAR and the Ativan controlled drug sign out sheet revealed that R7 received Ativan	F 329	heart rate are obtained and recorded for Losartan and Coreg. Medications are administered or held as per ordered parameters and documented accordingly to physician's orders. 2. MAR'S audited for ordered blood pressure/heart rate and holding medication parameters, TAR'S audited for lab orders/results, Behavioral Monitoring Record audited for side effects/effectiveness and non-drug interventions. 3. Licensed nurses in-serviced by staff development/designee on medication administration, recording on behavior monitoring record (side effects, effectiveness and non-drug interventions) and follow-up on lab orders & results. Random audits of MAR/Behavioral Records by nursing management of residents with parameters to hold medications, effectiveness and side effects of psychotropic medications and non-drug intervention	

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F 329	Continued From page 39 on 7/8, 7/13, 7/17, 7/19, 7/20, 7/21, and 7/22. Medication records, nurse's notes and CNA (Certified Nurse Aide) Flow sheets reviewed from 7/8/12 through 7/22/12 failed to indicate on six (6) occasions that R7 exhibited behaviors/symptoms that warranted the use of the Ativan. Additionally, there was no evidence that any non-pharmacological interventions had been attempted prior to the administration of the Ativan and there was no evidence of monitoring for potential side effects. Findings were acknowledged by E6 (Unit Manager) on 8/9/12 during an interview. 3. R47 was admitted to the facility on 1/15/10 and had diagnoses that included diabetes mellitus, congestive heart failure and osteoporosis. The 8/12 monthly physician's order sheet (POS) revealed that R47 was receiving Lasix (diuretic-water pill) 40mg daily, Spironolactone (potassium sparing diuretic) 25 mg daily, Glyburide (antidiabetic agent) 5 mg daily, Lantus (insulin) 8 Units daily and Vitamin D-2 1.25mg 1 capsule once a month. Physician orders, originally dated 12/1/11, revealed R47 was to have a BMP (blood work) drawn every 6 months in February and July, a Vitamin D-3 level drawn every 6 months in June and December and a HgbA1C (measures blood sugar control) every three (3) months. Review of the clinical record revealed that although a D-3 level was drawn on 6/11/12 and a laboratory sheet was in the chart, it stated that the results were "pending." There was no evidence in the clinical record that the D-3 level results had	F 329	prior to administration of PRN psychotropic will be completed 2x a week x 4, weekly x 4 then monthly x 4. Random lab audits by nursing management will be completed weekly x 4, then monthly 4. 4. Results will be submitted monthly to QA for review	10/9/12

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F 329	Continued From page 40 ever been received and reviewed. Review of the 7/12 treatment administration record (TAR) revealed that staff had checked off that a BMP and HgbA1C had been drawn on 7/5/12. The clinical record lacked evidence of results for these two (2) labs. On 8/9/12 at 10:55 AM, E6 (Unit Manager) called the laboratory and was told that there had not been a BMP or HgbA1C drawn on 7/5/12. The last BMP results found were dated 2/3/12 and the last HgbA1C result found was dated 5/2/12. Review of the 8/12 TAR revealed notations that the HgbA1C was not due to be drawn until October (2012) and that the BMP was not due until February (2013). Neither of these labs had been drawn in July as ordered. During an interview on 8/9/12 with E6 findings were reviewed and acknowledged. E6 was asked what their process or system was to verify the completion of the blood work and the results. E6 stated, "That's a good question." 4. R14 was admitted to the facility on 6/29/12 with diagnoses that included hypertension and coronary artery disease. R14's July and August 2012 Physician's Order Sheets included the following order, "Metoprolol Tartrate 25 mg (milligram) tablet 1/2 tablet (12.5 mg) by mouth twice daily *Hold for SBP (Systolic Blood Pressure/top number of blood pressure) < (less than) 110 or heart rate <60. Dx (Diagnosis): HTN (Hypertension)". Review of R14's July 2012 MAR (Medication	F 329		

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F 329	Continued From page 41 Administration Record) revealed that Metoprolol was administered on 7/7/12 at 6 AM, despite a heart rate (HR) = 58; on 7/21/12 and 7/24/12 at 6 AM, despite a HR = 57; on 7/16/12 and 7/20/12 at 4 PM, despite HR = 55. On 7/29/12 at 4 PM and 7/30/12 at 6 AM, the MAR lacked evidence that Metoprolol was administered or that vital signs had been done. Review of R14's August 2012 MAR revealed that Metoprolol was administered at 6 AM on 8/1/12, despite HR = 57 and on 8/2/12, despite HR = 29. During an interview on 8/6/12 at 2:30 PM, E6 (nurse manager) confirmed findings. She stated that medications should not be given when outside of parameters. The facility failed to ensure that R14 was free from unnecessary drugs when they administered her Metoprolol without adequate indications for its use and without adequate monitoring (outside of physician ordered parameters). 5A. R13 was admitted to the facility on 11/17/11 and readmitted on 4/23/12 with diagnoses that included heart failure, hypertension, dementia, and end-stage renal disease (ESRD). R13's July 2012 POS's had a physician's order which stated, "Lisinopril (antihypertensive) 2.5 mg tablet 1 tablet by mouth at bedtime. * Hold for SBP (systolic blood pressure/top number of a blood pressure) < (less than) 110". Review of R13's July 2012 MAR revealed that Lisinopril was administered on 7/12/12, 7/18/12 and 7/20/12 despite the lack of evidence that blood pressures were done at these times.	F 329		

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F 329	Continued From page 42 5B. R13's May 2012 POS's had a physician's order which stated, "Carvedilol 3.125 mg tablet 1 tablet by mouth twice daily *Hold for Systolic B/P. <120; Heart rate <65* Dx: HTN (hypertension)." Review of R13's May 2012 MAR revealed that Carvedilol was administered on 5/29/12 at 8 AM, despite HR = 61. Additionally, Carvedilol was administered at 8 AM on 5/1 through 5/3, 5/5, 5/6, 5/8 through 5/11and 5/16, and at 4 PM on 5/2 and 5/13/12, despite the lack of evidence that heart rates were done. Review of R13's June 2012 MAR revealed that Carvedilol was administered on 6/1/12 and 6/23/12 at 8 AM, despite HR = 64; on 6/16/12 at 4PM, despite SBP=111 and 6/29/12 at 4 PM, despite SBP = 108. Additionally, Carvedilol was administered on 6/10/12 and 6/15/12 at 8 AM, despite the lack of evidence that heart rates were done. R13's physician's order, dated 7/18/12 at 10 AM stated, "... Coreg (brand name for Carvedilol) 6.25 mg BID Hold for SBP<110; HR<60." This order remained the same on the August 2012 POS. Review of R13's August 2012 MAR revealed that Carvedilol was administered on 8/9/12 at 8 AM, despite the lack of evidence that a heart rate was done. E1 (Administrator) and E2 (Director of Nursing) acknowledged the findings during the exit on 8/14/12. The facility failed to ensure that R13 was free from unnecessary drugs when they failed to	F 329		

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F 329	Continued From page 43 adequately monitor vital signs and administered medications (Lisinopril and Carvedilol) without adequate indications for its use. 6.R75 was admitted to the facility on 7/22/10 and readmitted on 7/12/12 with diagnoses that included Coronary Artery Disease, Hypertension, Congestive Heart Failure and Parkinson's Disease. Review of R75's May, June and July 2012 monthly physician's order sheets included an order for the medications, Losartan Potassium (antihypertensive) 50mg (milligram) one tablet by mouth once a day and Carvedilol (antihypertensive) 6.25 mg one tablet by mouth twice a day. The order also indicated parameters to hold these medications for a systolic blood pressure (SBP- top number of the /BP reading) less than 110 and a HR (heart rate) less than 60. Review of the May 2012 MAR (Medication Administration Record) revealed that R75's BP at 4 PM on 5/6/12 was 96/62, 5/19/12 BP was 102/64 and 5/22/12 BP was 107/70 however, R75 was administered Carvedilol, despite the parameters. Review of the June 2012 MAR revealed that on 6/1/12 there was no BP or HR completed and the Losartan Potassium was given, and on 6/18/12 at 4PM, R75's BP was 108/70 and the Carvedilol was given. Review of July 2012 MAR revealed that on 7/9/12 at 8 AM, R75's BP was 100/80 and on 7/11/12 at 8AM BP was 108/63 and the Losartan Potassium was given. On 7/5/12 at 4PM there was no pulse	F 329		

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F 329	Continued From page 44 taken and the Carvedilol was given. During an interview on 8/10/12, E2 (Director of Nursing) acknowledged that R75 should not have received Carvedilol/Losartan when R75's SBP was outside of the ordered parameters and/or when blood pressure/pulse were not obtained before medications were given. On 8/13/12 E2 (DON) provided a copy of the facility's Medication Error Report form, dated 8/11/12, which described the incident as, "med given without proper parameters observed" and "med given without pulse charted ". F/U (Follow-up) and education provided to nurses involved." The facility failed to adequately monitor R75's medication and despite the physician ordered parameters for SBP and HR, administered doses of Carvedilol/Losartan to R75 that should have been held.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that one (R1) out of 10 residents sampled during the medication pass observation was free of significant medication errors. Findings include:	F 333	1. R 1 Dilantin Elixir is accurately calibrated and administered. Dilantin Level will be monitored via lab work per physicians order. 2. Currently no other residents are receiving Dilantin Elixir. Licensed nurse have been observed for med pass for residents receiving liquid medication for appropriate administration technique	

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F 333	Continued From page 45 R1 was re-admitted to the facility, post hospitalization on 7/24/12 with diagnoses which included stroke, hypertension and seizure disorder. On 8/7/12 at approximately 9:30 AM, E7 (nurse) was observed preparing and dispensing morning medications for R1. Phenytoin (seizure medication) 125mg/5ml suspension 4 ml (100 mg) was drawn up via a syringe and placed into a medication cup by E7. E7 poured the Phenytoin 4mls into a piston syringe which was connected to R1's feeding tube, placed the medication cup to the side and flushed the feeding tube. E7 proceeded to administer other medications via the feeding tube, flushed the tube and then capped it off. Observation of the medication cup which had contained the Phenytoin suspension revealed that residual medication was left at the bottom. When questioned about the residual left in the cup, E7 stated that she probably should have added some water to the cup to ensure that all the medication was given. E7 proceeded to do so. The manufacturer's package insert states on page 6, "Patients should be instructed to use an accurately calibrated measuring device when using this medication to ensure accurate dosing." Although E7 used a calibrated measuring device to measure out the Phenytoin dose, she, failed to ensure that R1 received an accurate dose of the medication when the residual would have been left in the medication cup.	F 333	3. 100% Med pass observations will be completed by nursing management for appropriate technique, random weekly x 3 months 4. Results will be submitted monthly to QA for review	10/9/12
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		

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F 356	Continued From page 46 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the information contained on the posted staffing sheets was complete. Findings include: Review of the facility staffing sheets reviewed	F 356	1. Posted Nurse Staffing Information form updated to include total number and the actual hours worked by licensed & unlicensed nursing staff directly responsible for residents direct care q shift and resident census 2. Nursing staffing form and policy updated 3. Nursing management and nursing scheduler in-serviced on required nurse staff posting. Staff posting will be monitored by NHA/designee on rounds weekly x 4 4. Results will be submitted to QA for review	10/9/12

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F 356	Continued From page 47 from 8/2/12 to 8/14/12 that were posted throughout the facility failed to contain the following information as required: The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses or licensed vocational nurses (as defined under State law), and the Certified Nurse Aides. Additionally, the staffing sheets failed to include the resident census. During an interview on 8/10/12 at 2:55 PM, findings were confirmed/acknowledged by E1 (Administrator) and E2 (Director of Nursing).	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	1. Bedpans in room 215 have been replaced, labeled , bagged and stored properly 2. Rounds have been made to ensure bedpans in all rooms are properly labeled, bagged and stored 3. CNA and housekeeping staff in-serviced on proper labeling, bagging and storing of residents bedpans. Labeling, bagging and storage of bedpans will be monitored staff development/designee weekly x 3 months 4. Results will be submitted monthly to QA for review	10/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 08/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

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F 441	Continued From page 48 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide a safe, sanitary and comfortable environment that ensured prevention of the development and transmission of disease and infection. Findings include: Observation on 8/2/13 at 10:20 AM of the bathroom in room #215 revealed two (2) bedpans stored on top of the toilet pipes. The bedpans were not labeled or bagged and one had brown debris on it. A sign posted over the toilet stated, "No bedpans or urinals are to be left in the bathroom..." E6 (Unit Manager) confirmed on 8/2/13 that bedpans should not be stored in the bathroom, that they should be labeled, bagged and stored in the resident's bedside drawer. E6 also stated that	F 441		

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	085012	A. BUILDING _____ B. WING _____	C 08/14/2012

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F 441 F 514 SS=E	Continued From page 49 the toilet was shared between four (4) residents. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records for five (R7, R13, R50, R79 and R118) out of 37 sampled residents in accordance with accepted professional standards and practices that are complete and accurately documented. Findings include: 1.There was no follow-up documentation related to a change of plans to address a delay of R118's discharge planning in a timely manner. E4 (Social Services) acknowledged this finding on 8/13/12. 2. C.N.A. Team Leader Resident Care Conference Audit, dated 8/1/12 completed by E21 (CNA) for R79 revealed inaccurate information for this resident's assessments. E21	F 441 F 514	1. R 7 skin tear is healed; physician & RP have been updated. Medication Error report has been completed. Physician and Family were notified. R 13 Blood pressure is obtained and recorded for Carvidilol, as ordered. Medications are administered or held as per ordered parameters and documented accordingly to physician's order. Fluid restriction has been discontinued as per Physician orders. Accu-checks recorded and insulin/sliding scale administered per physicians order. MAR has been updated to include late entry of apical pulse R 118 Discharge plan has been update and reflected correctly in the care plan. R 79 Care conference audit was corrected to indicate that resident does have dentures R 50 Resident's snacks are documented according to	

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F 514	Continued From page 50 documented under oral assessment that R79 had no dentures (circled N) and had own teeth (circled Y) checked marked upper and lower teeth in good condition. R79 had upper and lower dentures and did not have his own teeth. 3. It was observed on 8/7/12 at 10:45 AM that E12 (LPN) signed off as given on R50's MAR (Medication Administration Record) the 8/7/12 12:00 PM snacks and the 2:00 PM snacks and percent consumed as 100% before it was time to give the snacks. These findings were discussed and acknowledged by E1 and E2 on 8/14/12. 4a. Review of R7's clinical record lacked any documentation regarding the skin tear the resident sustained on 7/13/12 to his left hand. Findings were acknowledged by E2 (Director of Nursing) on 8/9/12. 4b. Review of R7's Ativan controlled drug sign out sheet revealed that doses were administered on 7/8/12, 7/13/12, 7/17/12, 7/19/12, 7/20/12, 7/21/12, and 7/22/12. Review of the 7/12 medication administration record (MAR) revealed that staff failed to sign off on the MAR the doses that were given on 7/8, 7/13, 7/17, and 7/19/12. Findings were acknowledged by E6 on 8/9/12. 5A. According to R13's 5/12 MAR (medication administration record), R13 was on a 1500 ml/day fluid restriction to be divided between dietary (900 ml) and nursing (600 ml). Nursing was to be	F 514	time ordered to indicate percentage consumed. 2. Physicians and RP's have been notified for all residents with Change of Condition. Fluid restriction policy was reviewed and revised. All residents ordered fluid restrictions were reviewed to comply with updated policy. All care plans have been reviewed/up-dated for change in discharge planning. Nursing Staff ave been in serviced on documenting the snack percentage after consumption. C.N.A. Team Leader has been in-serviced on accurately completing resident care conference audit. Controlled medications are being recorded on MAR and controlled medication record 3. Licensed nursing staff has been in-serviced by staff development/designee on notification policy. Notification documentation will be reviewed in morning clinical meeting. A random audit of notification documentation will be completed	

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F 514	Continued From page 51 divided as 7-3 shift=360 ml, 3-11 shift=120 ml and 11-7 shift=120 ml. There was no documentation of the fluid restriction monitoring on 5/18/12 through 5/22/12 and 5/29/12 through 5/30/12. 5B. According to R13's 6/12 POS (Physician's Order Sheet), R13 had an order for accuchecks to be done before meals and at bedtime with a sliding scale coverage. Review of R13's 6/12 MAR revealed that on 6/15/12 at 9 PM, the MAR was signed off as done, however, the facility staff failed to record/indicate the blood sugar value and if insulin coverage was necessary and/or the amount administered. Additionally, there was no documentation of R13's fluid restriction on 6/30/12. Findings were acknowledged by E6 on 8/10/12. Cross refer F329, Example 5B. 5C. R13's 8/12 POS stated, "Carvedilol 6.25 mg 1 tablet by mouth twice daily. *Hold for SBP<110; HR<60." Review of R13's 8/12 MAR on 8/10/12 revealed that Carvedilol was administered on 8/9/12 at 8 AM, despite the lack of evidence that a heart rate was done. However, on 8/14/12, after an updated copy of the 8/12 MAR was obtained, the heart rate was now documented as "76" with no late entry or other documentation on the back of the MAR or nurse's note to explain this.	F 514	by Unit Manager/designee weekly x 4 weeks, then monthly x 2 months. All Licensed nurses have been in serviced by staff Development/designee on fluid restriction, snacks and accu-checks/with sliding scale documentation. Random audits of fluid restriction, snacks and accu-checks with sliding scale documentation will be completed by Unit Manager/designee weekly x 4 then monthly x 4. MDS coordinator will educate C.N.A Team Leaders on accurate documentation of the care conference audit. Random audits of care conference audits will be completed by MDS coordinator/designee weekly times 4 weeks and monthly times 3 months. Interdisciplinary team has been in-serviced by staff development/designee on updating care plans in a timely manner and change in discharge planning. Care plans will be updated as needed. Care plans will be randomly audited by MDS coordinator/designee weekly x 4, then monthly X 3 months 4. Results will be submitted to QA/QI monthly for review.	10/4/12

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Regency Health Care

DATE SURVEY COMPLETED: August 14, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from August 2, 2012 through August 14, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 96. The Stage 2 sample totaled 37 residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report dated 8/14/12, F157, F225, F241, F253, F280, F309, F315, F323, F329, F333, F356, F441, F514.	Cross reference to CMS-L Survey Pan of Correction dated 8/14/2012, F157, F225, F241, F253, F280, F309, F315, F323, F329, F333, F356, F441, F514
201.9.0	**Records and Reports**	

Provider's Signature [signature] Title [signature] Date 9/7/12

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3201.9.5 3201.9.6	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** **All incident reports whether or not required to be reported shall be retained in facility files for three years.** **Based on record review and interview, it was determined that the facility failed to complete an incident form for an alleged resident to resident abuse without injury between two (2) residents (R2 and R49). Findings include:** **This requirement is not met as evidenced by:** Review of R2's Social Services Assessment completed 6/26/12 was coded for both physical and behavioral symptoms that occurred 1-3 days. On 8/10/12 at 8:32 AM, the incident report for R2 was requested by the surveyor. During an interview on 8/10/12, E4 (Social Worker) provided a concern form dated 6/26/12, from R49 that alleged that R2 cursed and hit him when he refused her request for a cigarette. E4 stated that R49 denied any injuries.	**3201.9.6** 1. R2 incident report completed for resident to resident abuse, RP and physician notified. Care plan updated and no Further incidents have occurred R49 incident report completed for residents to resident abuse, RP and physician notified. There was no injury and or psychosocial distress 2. August resident concern forms have been reviewed for resident to resident allegations of abuse to assure incident report(s) was completed as warranted 3. Nursing staff and social services have been in-serviced by staff development/designee on completion of incident reports for alleged resident to resident abuse. Concern forms will be reviewed by interdisciplinary team at morning meeting to determine if incident report is needed and or completed. Random audit concern forms will be completed by NHA/designee weekly x 4 then monthly x 3 4. Results of audits will be reviewed monthly at QA 10/9/12

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	During an interview on 8/10/12 at 9:10 AM, E2 (Director of Nursing) stated that a concern form had been completed on 6/26/12. E2 stated that this was a resident to resident abuse without injury and was not reportable to the state. She stated that an incident report was just completed for R2 and R49 this morning, the physician (who was the same physician for both residents) was notified this morning and the families of both residents would be notified of the 6/26/12 incident as soon as possible. E2 acknowledged that an incident report had not been completed as required. The facility failed to have an incident report that had been completed at the time of the occurrence for R2 and R49.	
3201. 9.7	**Incident reports which shall be retained in facility files are as follows:** **9.7.6 Skin tears.** **This requirement is not met as evidenced by:** Based on observation, record review and interview, it was determined that the facility failed to complete an incident report when R7 sustained a skin tear on 7/13/12. Findings include: R7 was admitted to the facility on 7/2/12 with diagnoses that included dehydration, debility and C2 (cervical spine) fracture. The 7/2/12 nursing admission note stated R7 had a scabbed area on the left wrist. Observation of R7 on 8/2/12 at 11:49 AM revealed that he had a skin tear on his left hand which was covered by Tegaderm (clear wound dressing). R7 stated that he had hurt it on his wheelchair.	3201.9.7 1. R7 incident report for skin tear completed, RP and physician notified 2. All skin tears have been reviewed to assure incident report was completed & notification of RP and physician 3. License nurses have been in-serviced by staff development/designee on incident reporting for skin tears/change of condition. Incidents will be reviewed in morning clinical meeting. A random weekly audit of incident reports will be completed by Unit Manager/designee weekly x 4 weeks, then monthly x 2 months 4. Results of audits will be reviewed monthly at QA 10/9/12

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	On 8/8/12, the incident report was requested by the surveyor. The facility failed to have an incident report that had been completed at the time of the occurrence. E2 (Director of Nursing) acknowledged that an incident report had not been completed as required.	